Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Zepbound (tirzepatide) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Zepbound (tirzepatide)** for **MD Medicaid** plans. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication:

   _____

3. Patient does not have Type 1 or 2 Diabetes?

   □ Yes

Clinical Criteria:

4. Is the medication being prescribed by or in consultation with a sleep specialist, pulmonologist, or other provider experienced in treating OSA?

   □ No □ Yes

5. Does the patient have moderate to severe OSA, as diagnosed by polysomnography with an apnea-hypopnea index (AHI) ≥15 events per hour?

   □ No □ Yes

6. Is the patient's BMI ≥30 kg/m^2?

   □ No □ Yes

7. Provide current height and weight measurements from within the last 90 days:

   Current height: _____ Current weight: _____

8. Does the patient meet FDA-approved clinical parameters for use as set in prescribing information (i.e., no contraindications, appropriate screening and monitoring have been completed)?

   □ No □ Yes

9. Does provider attest that patient will NOT be using this medication concurrently with other GLP-1 receptor agonists?

   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below.

10. Is there provider attestation of continued clinical benefit, and have subsequent evaluations and monitoring been performed?

    □ No □ Yes

11. Does the patient's BMI remain ≥30 kg/m^2? (Note: renewal will NOT be authorized if BMI is <30 kg/m^2)

    □ No □ Yes

12. <u>If patient has been on therapy for 12 months or longer:</u> Is there repeat documentation confirming that patient still has moderate to severe OSA? *(Note: annual documentation is required for subsequent renewals)*

    □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**